A. OTHER THIRD PARTY LIABILITY (TPL) COVERAGE

The Wisconsin Medical Assistance Program (WMAP):

- is the payor of last resort ; and
- reimburses the portion of the allowable cost remaining after all other third party sources have been used.

Refer to Section IX-D of the WMAP Part A Provider Handbook for more detailed information on services requiring third-party billing, exceptions, and the "Other Coverage Discrepancy Report."

B. MEDICARE/ MEDICAL ASSISTANCE DUAL ENTITLEMENT

Recipients covered under both Medicare and Medical Assistance are referred to as dual-entitlees. Claims for Medicare covered services provided to dual-entitlees must be billed to Medicare prior to billing Medical Assistance.

If the recipient is covered by Medicare, but Medicare denied the claim, a Medicare disclaimer code must be indicated on the claim, as explained in the claim form instructions in Appendix 2 of this handbook.

C. QMB-ONLY RECIPIENTS

Qualified Medicare Beneficiary Only (QMB-Only) recipients are only eligible for WMAP payment of the coinsurance and the deductibles for Medicare-covered services. (Since Medicare covers ambulance services, claims submitted for QMB-Only recipients are reimbursed.)

D. BILLED AMOUNTS

Providers must bill the WMAP their usual and customary charge for services provided. The usual and customary charge is the amount charged by the provider for the same service when provided to private-pay patients. For providers using a sliding fee scale for specific services, usual and customary means the median of the individual provider's charge for the service when provided to non-Medical Assistance patients. Providers may not discriminate against Medical Assistance recipients by charging a higher fee for the service than is charged to a private-pay patient.

E. CLAIM SUBMISSION

Paperless Claim Submission

As an alternative to paper claim submission, EDS is able to process claims submitted on magnetic tape (tape-to-tape) or through telephone transmission via modem. Claims submitted through these systems have the same legal requirements as claims submitted on paper and are subjected to the same processing requirements as paper claims. Software for electronic submissions may be obtained free of charge. Electronic submissions have substantial advantages in reducing clerical effort and errors, reducing mailing costs and delays, and improving processing time. Additional information on paperless claim submission is available by contacting the Electronic Media Claims (EMC) Department at:

EDS
Attn: EMC Department
6406 Bridge Road
Madison, WI 53784-0009
(608) 221-4746

A sample EMC screen can be found in Appendix 1d of this handbook.

Paper Claim Submission

Ambulance services must be submitted using the HCFA 1500 claim form. A sample claim form and completion instructions are in Appendices 1 and 2 of this handbook.

Ambulance services submitted on any other paper form than the HCFA 1500 claim form are denied.

E. CLAIM SUBMISSION (continued)

The HCFA 1500 claim form is not provided by the WMAP or EDS. It may be obtained from a number of forms suppliers including:

State Medical Society Services, Inc.
Post Office Box 1109
Madison, WI 53701
(608) 257-6781
1-800-362-9080

Completed claims submitted for payment must be mailed to:

EDS
6406 Bridge Road
Madison, WI 53784-0002

Submission of Claims

All claims for services rendered to eligible WMAP recipients must be received by EDS within 365 days from the date such service was rendered. This policy pertains to all initial claim submissions, resubmissions, and adjustment requests.

Exceptions to the claim submission deadline and requirements for submission to Late Billing Appeals are in Section IX-F of the WMAP Part A Provider Handbook.

F. DIAGNOSIS CODES

Ambulance providers must use the appropriate diagnosis code for the service that is provided:

V919 - Emergency
V920 - Nonemergency Prescription on File

G. PROCEDURE CODES

All claims submitted to the WMAP must include procedure codes. HCFA Common Procedure Coding System (HCPCS) codes are required on all ambulance claims. Claims or adjustments received without HCPCS codes are denied. Allowable HCPCS codes and their descriptions for ambulance services are listed in Appendix 3 of this handbook.

H. FOLLOW-UP TO CLAIM SUBMISSION

It is the provider's responsibility to initiate follow-up procedures on claims submitted to EDS. Processed claims appear on the Remittance and Status Report either as paid, pending, or denied. Providers are advised that EDS will take no further action on a denied claim until the information is corrected and the claim is resubmitted for processing. If a claim was paid incorrectly, the provider is responsible for submitting an adjustment request form to EDS. Section X of the WMAP Part A Provider Handbook includes detailed information regarding:

- the Remittance and Status Report;
- adjustments to paid claims;
- return of overpayments;
- duplicate payments;
- denied claims; and
- Good Faith claims filing procedures.